

Allergic rhinitis: common, costly, and neglected

The cost of allergic rhinitis in the USA is nothing to be sniffed at. According to a report published last week by the Agency for Healthcare Research Quality, in 2005, Americans spent US\$11bn on doctors' bills, prescription drugs, and other medical care to relieve allergy symptoms such as itchy, watery eyes, stuffy noses, wheezing, coughing, and headaches—almost double that spent in 2000. Some 22 million Americans visited their doctor because of allergy symptoms, with doctors' bills accounting for about a third of allergy costs. The remainder mostly went on prescription drugs, such as the antihistamines loratadine and cetirizine, with an average annual spend of \$520 per person. As the report only focused on allergies to pollen, dust, and animal hair, these soaring costs do not include treatment for allergies caused by other substances, such as the growing phenomenon of food allergies.

But do these increasing costs reflect an increasing prevalence of allergies? It would appear so. In the UK, a wealth of data—much of it summarised in the 2007 House of Lords *Science and Technology Committee Allergy Report*—confirm that allergy symptoms have increased over the past few decades. 3.3 million people in England have a recorded diagnosis of allergic rhinitis—interestingly roughly the same proportion as in the USA. Studies to date have found a high prevalence of seasonal allergic rhinitis across all of western Europe. However, the seasonal and perennial nature of this condition often thwarts epidemiological surveys. To improve the monitoring of the condition, WHO has proposed that allergic rhinitis be classified by whether symptoms are intermittent or persistent.

Although there is no consensus on the reasons for the increased prevalence of allergies, the “hygiene hypothesis” has solid support. First proposed by David Strachan in the 1980s, this hypothesis suggests that children exposed to poor hygiene and increased infections in early life have lower levels of IgE sensitisation and allergic diseases. In other words, squeaky-clean modern life could be a contributing factor, and may indeed be harmful to children. Another commonly cited contributing factor is environmental pollution. Whatever the reason, there is no doubt that allergy symptoms are increasing, can be debilitating, and often cause much misery and suffering. Societal costs are also substantial because of negative effects on educational attainment and loss of productivity

at work. Furthermore, the medical profession has little idea about how to manage allergy-prone patients.

The Royal College of Physicians and the Department of Health have both warned that there are not enough allergy specialists in the UK. There are only six specialist centres in the UK, and cash-strapped Primary Care Trusts put allergy treatment and management, including that for allergic rhinitis, near the bottom of their priority list. In addition, according to the National Allergy Strategy Group, general practitioners are poorly informed about allergies and have very little training in this area. Although more specialists would of course be a welcome start, just to add to the confusion, the evidence base for effective treatment and management is scarce. There are currently no guidelines from the National Institute for Health and Clinical Excellence on the treatment of allergies. And current practice often goes against the evidence base for what interventions are effective in the prevention or treatment of allergies. For example, as we discussed in a *Lancet* Editorial on April 26, a recent Cochrane Review concluded that there is no evidence for the commonly used physical and chemical interventions, such as mattress protectors and sprays, to control house dust mites. Yet these interventions are currently being widely promoted by the health community.

People with allergies are being badly let down. There are inadequate facilities, resources, and specialists to investigate, manage, and treat them. But this disappointing situation could be turned around with the help of a health worker cadre that is frequently overlooked but often the first point of contact for people with allergies—community pharmacists. The Pharmaceutical Group of the European Union represents around 400 000 community pharmacists in 30 European countries and estimates that over 46 million Europeans visit their community pharmacies every day. According to the UK Royal Pharmaceutical Society, allergy is a large focus of the 5-year education and training pharmacists receive and earlier this year, pharmacists with an interest in allergy screening were invited by the UK National Pharmacy Association to sign up for training. Community pharmacists are keen, willing, and able to do more in primary care and so should grab the opportunity to step up and fill the cavernous hole of allergy knowledge, treatment, and management. ■ *The Lancet*



For the report from the Agency for Healthcare Research Quality see http://www.meps.ahrq.gov/mepsweb/data_files/publications/st204/stat204.pdf

For the 2007 House of Lords *Science and Technology Committee Allergy Report* see http://www.parliament.uk/parliamentary_committees/lords_s_t_select/allergies.cfm

For our previous Editorial on dust-mite control measures see *Lancet* 2008; 371: 1390